Q: Realistic Coding
To support realistic medicine discussions we need to ensure we can code these to then support searches in the future. Unlike QOF, we don't need everyone on antcoag, but they should all be on it, offered it or it's contraindicated. Likewise for statins, intensifying diabetes treatment, intensifying BP treatment, cholesterol, bisphosphones etc. It would make a huge difference to be able to say for the quality of ongoing LTC care that 100% of pts in your practice have been offered an intervention. Whether they do it or not doesn't matter, but all should have had that discussion. It's more nuanced than 'exception coding'. I note there is one for anticoagulant (8I3d); but there could be more and it's not on the recommended SCIMP list. This could form a good corner stone to evolving LTC work we are about to begin next week with HIS/SG/RCGP. If you wish to discuss further, please email. thanks.

Then followed this up with clarification:

In long-term condition care, where someone declines an intervention/escalation in a shared decision we should be able to code it in an approved code.

With this, we will then be assured as we create the systems around the future LTC care all people are either on an intervention, have been offered and declined, or it's contraindicated.

This would apply to most long-term conditions.

e.g.

'Shared decision making: declined escalation of cholesterol lowering therapy'
'Shared decision making: declined escalation of glycaemic control'
'Shared decision making: declined escalation of bone protection'
'Shared decision making: declined antiplatelet/anticoagulation therapy'
'Shared decision making: declined escalation of hypertension therapy'

When we then put this in place as a priority 1 code, it will be far easier to then assure that as we start to release data to show practices where they are at with LTC care, they can be assured it's OK that it's not they've neglected any patients in follow up, it's that the patient share a decision with the clinician to decline the intervention.

As it stands for example we have falling rates of anticogulation for example being offered to those with AF. We don't know if this is because pts are declining or if not being offered. With a promoted agreed read code, we could assure that all were offered. (there is a code for anticogulation declined, but it's not approved as an aside).

A:
Many thanks for contacting SCIMP about this important area. The coding challenges for 'Realistic Medicine' are significant and it will be hard to provide national evidence that the CMO's goal "by 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine" has been obtained without addressing this. We agree that this is more nuanced than 'exception coding'.

If as the Long Term Conditions work progresses and discussion with Healthcare Improvement Scotland, Scottish Government and Royal College of General Practitioners lead to a request for more codes this could be performed. The process would be to generate new Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT), mapped to newly generated supplier local

Read codes. SNOMED CT is a polyhierarchy of terms that NHS Scotland plan to implement and importantly includes attribute relationships, unlike Read codes. There is an established process of requesting new SNOMED entries, although the process is more complicated as Read codes also are required to be generated so they can be used in existing systems. This a process we are trying not to undertake unless absolutely necessary. Thought would need to be given to the exact codes that are requested to assist coding these important discussions that involving shared decision making. If this is the direction that will be taken SCIMP could support this by liaising with the NHS National Services Scotland Terminology team and provide input into the exact terms requested.

However, SCIMP would like to express caution here. QOF was scrapped, after many GPs who had regarded this as a box ticking exercise. There is a potential for an unintended consequence to occur here with excessive time spent coding and perhaps time could be better spent trying to optimise correct coding of important conditions and providing patient care. We believe it is likely that these newly generated codes documenting 'realistic medicine' discussions may not be particularly well received by GPs.

Currently GPs record these discussions in free text, meaning that they have this discussion documented in the clinical record. This can be used to assist future discussions and for medico-legal purposes, if necessary. This in many ways is fit for the primary purpose of providing health care, however is not suitable for secondary purposes of assessing data nationally. If new codes are generated, added into the summary of a patient's record this would lead to it becoming cluttered. For example when situations arise in which a patient changes their mind a few weeks later. Additional time could then be spent modifying the medical record again.

One SCIMP colleague, who is an experienced informatician working in both a Scottish, UK and international context, elaborated:

"The need for what is suggested is obvious but going down the route of trying to throw only SNOMED or READ codes at the problem will lead to insanity. We already saw some of this around the EPACCS systems in England - Palliative care, where people were trying to carry reflect patients being on a 'pathway' or refusal to do so with a set of codes. The problem is that you end up with a whole set of 'discussed', 'declined', 'accepted', re-accepted codes for every single local care pathway program and you end up with a blizzard that becomes very hard for GP systems to work with and, [in addition] then have the further problem of differing prioritisation tags in 'generic GP problems'. In my opinion we need to get away from this a general approach. This needs a generic concept of care plan/pathway which uses one code to say what the plan/pathway is, and other 'generic' codes to flag the current status, pulled together in something like and openEHR archetype or FHIR profile. It is up to GP system suppliers to make this work under the hood."

OpenEHR archetypes[1] are a technology agnostic way of recording clinical concepts, Fast Health Interoperability Resource profiles are a form of Health Level 7 structure[2] that allows concepts to be recorded in a way that can be transferred between systems.

Please re-contact SCIMP in future if you would like to pursue new codes and we will do our best to assist, although would once again express caution here. If you do wish to pursue new codes we would also liaise with the Royal College of General Practitioners Health Informatics Group (HIG), about this, many SCIMP members are also members of HIG. Obtaining their views would help obtain a wider United Kingdom perspective.

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1 https://openehr.atlassian.net/wiki/spaces/healthmod/pages/2949191/Introduction+to+Archetypes+and+Archetype+classes

2 http://www.hl7.org/implement/standards/product_brief.cfm?product_id=491